American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jules Francois Parisien MD (Applicant)	AAA Case No.	17-20-1176-3189
	Applicant's File No.	361
- and -	Insurer's Claim File No.	349055001
	NAIC No.	10839
Country-Wide Insurance Company (Respondent)		

ARBITRATION AWARD

I, Tracy Morgan, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: injured person-assignor

1. Hearing(s) held on 03/24/2021
   Declared closed by the arbitrator on 03/24/2021

   Maria Shteysel, Esq. from Shteysel Law Firm, P.C. participated for the Applicant

   Saroja Cuffey, Esq. from Jaffe & Velazquez, LLP participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,773.69**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute to $1,505.90 acknowledging Respondent's partial payment.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The Applicant is the assignee of no-fault benefits from injured person-assignor (JM), a 34 year old male who was involved in a motor vehicle accident on February 27, 2020. Following the accident, the injured person-assignor underwent an office visit and

dry needling on June 29, 2020 performed by Applicant. Respondent partially paid and denied the balance contending that Applicant's fees exceed the maximum amount owed under the applicable fee schedule.

The issue presented on this arbitration is whether Respondent established that it properly reimbursed the Applicant?

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed the relevant exhibits contained in the electronic file maintained by the American Arbitration Association and have considered all of the stipulations and arguments presented by both parties at the hearing of this matter. No witnesses appeared or testified.

A health care provider establishes its prima facie entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms were mailed to and received by the insurer and that payment of no-fault benefits is overdue *See Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g];Viviane Etienne Medical Care, P.C. v Country-Wide Ins. Co.*, 25 NY3d 498 (2015).

I find that Applicant established its prima facie entitlement to first person no-fault benefits as proofs of claim were mailed to and received by the insurer and payment of No-Fault benefits is overdue.

Pursuant to both the Insurance Law and the Regulations promulgated by the Superintendent of Insurance, an insurer must either pay or deny a claim for no-fault benefits within 30 days from the date an applicant supplies proof of claim *See, Insurance Law §5106[a]; 11 NYCRR 65.15[g]; Presbyterian Hosp.in City of N.Y. v Maryland Cas. Co.*, 90 NY2d 274, 278 (1997).

Respondent received Applicant's claims and paid the office visit in full. As to the needling, Respondent paid 1 unit of CPT Code 20999 in full and paid a 2d unit of CPT Code 20999 at a reduced rate of $19.10. Respondent denied payment for the remaining 12 units billed under CPT Code 20999 as 20999 is a by report code described as an unlisted procedure.

As per Section 5108 of the New York State Insurance Law, a provider shall not exceed the charges permissible under the schedules prepared and established by the chairman of

the Workers' Compensation Board. The rates charged by Applicant must be in accordance with Insurance Law § 5108. The services in dispute were performed subsequent to the effective date, April 1, 2013, of the Fourth Amendment to Regulation 68-C. Sub division (g) (1) of No-Fault Regulation 65-3 now states that proof of fact that the amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical services that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defense *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co*., 13 Misc3d 172 (Civ. Ct. Kings Co., 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained *See Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc3d 145A (App Term, 1st Dep't, per curiam, 2006).

CPT Code 20999 is a By Report code. A "By Report" item is an item for which no relative value is established pursuant to the fee schedule. The Workers' Compensation Fee Schedule sets forth reporting requirements for services billed with CPT codes which are "by report" including pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

Applicant's bill indicates that the services were performed in Brooklyn, New York which falls within the fee schedule's region IV. Applicant billed 15 line items under by report code 20999 consisting of 5 different muscle groups at $100.00 each and 3 additional needling units for each group utilizing modifier 59 at $75.00 each.

Applicant submitted the evaluation report of physician's assistant Ebone Legall, P.A. documenting complaints of pain, a diagnosis of low back pain and other dorsalgia and identifying the bilateral muscle groups where the dry needling was performed.

The report does not provide a description of the nature, extent, and need for the procedure or service, the time, the skill or equipment needed.

Applicant also submitted the Affirmation of Jules Parisien, M.D. who concluded that CPT Code 20999 is the proper code to bill for dry needling. He explained that CPT Code 20553 is properly used for trigger point injections which are not the same as dry needling. Dry needling involves pushing thin filament needles through skin and muscle to release trigger points. It is dry needling because no solution is injected. Trigger point injections only take a few minutes to perform whereas dry needling takes 45 minutes to an hour. Further, dry needling is not the same as acupuncture needling since dry needling targets specific areas of myofascial muscle and tissue connecting muscle and the needles are inserted deeper than acupuncture needles. Dry needling is performed on more than one muscle and the value is $75.00-$100.00 per muscle. The RVU is based upon the skill, time, expertise and complexity of the procedure.

Dr. Parisien failed to provide an analysis regarding what RVU should be utilized for this by-report code. He stated that the RVU was based on skill, time expertise and complexity of the procedure but does not give any details for this procedure. In a general manner she stated that dry needling takes 45 minutes to one hour but there is no indication in his Affirmation or the procedure report as to how much time elapsed for the services here. Additionally, the report is prepared by a physician's assistant and it is unknown who performed the procedure. No details as to the skill or expertise required was set forth. Other than identifying which muscles were treated, there is no description of the complexity level for this procedure.

I find Applicant's submissions insufficient to support its use of a by report code. The Ground Rule requires "[p]ertinent information concerning the nature, extent, and need for the procedure or service, [and] the time." None of the documents set forth a relative value unit consistent in relativity with other relative value units shown in the schedule. Moreover, it appears that the $75.00 and $100.00 fee for each unit is excessive and arbitrary. As such, the submissions fail to justify Applicant's fees.

To support its reduced payment, Respondent submitted the fee schedule affidavit of Jennifer Budden, a certified billing and coding specialist certified by National Healthcareer Association. Ms. Budden explained that Applicant billed the services using a By Report code, CPT code 20999, and that based on the ground rules of the New York State Workers' Compensation Board Medical fee schedule, an insurer is instructed to review a provider's charge for consistency in relativity with the closest similar procedure that has an established relative value in the fee schedule. She indicated that CPT code 20553 is the closest similar procedure as it is utilized for trigger point injections for

single or more muscles. She referenced Ground Rule 5 of the Surgical section of the fee schedule and indicated that payment is for the highest procedure at 100% plus half of the lesser procedures. She concluded that $119.10 is the appropriate amount of reimbursement without explaining how she came to that figure. Applicant charged $100.00 for the 5 different muscle groups and the additional needling was billed at $75.00. By reimbursing the first charge at $100.00 it is unknown how she computed that only an additional $19.10 should be paid.

I am guided by the reasoning set forth by Arbitrator Drew Gewuerz in AAA Case number 17-18-1108-5230 wherein Arbitrator Gewuerz determined:

"The AMA's position is to use code 20999 which is found in the CPT Assistant, October 2014. The CPT Assistant's guidance is persuasive. See generally AAA Case No.: 17-16-1052-3177. So, while the Applicant's chosen CPT code assignment is proper, the issue remains, however, what the proper reimbursement amount should be. The CPT Assistant provides further guidance on this issue stating in the same volume, "codes from the (20550-20553) code range are not intended for reporting a "dry needle" technique." The CPT Assistant, which preserves the American Medical Association's intention, is that codes for trigger point injections, injections to the tendon or tendon sheath are inapplicable to the disputed services. From this, the applicability of the frequency assigned to said codes by the Respondent is unpersuasive. As a result, this Arbitrator is constrained to award the amount in dispute due to the Respondent's failure to provide competent, persuasive substantive evidence disputing the billed amounts."

After a review of the evidence on this Record, I find that Respondent failed to establish its fee schedule defense. Accordingly, Applicant is awarded the balance in the amount of $1,505.90. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

5. Optional imposition of administrative costs on Applicant.
   Applicable for arbitration requests filed on and after March 1, 2002.

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle

☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	Jules Francois Parisien MD	**06/29/20 - 06/29/20**	**$148.69**	**$0.00**	**Withdrawn with prejudice**
	Jules Francois Parisien MD	**06/29/20 - 06/29/20**	**$1,625.00**	**$1,505.90**	**Awarded: $1,505.90**
Total			**$1,773.69**		**Awarded: $1,505.90**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/23/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

As this matter was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d) For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to a maximum fee of $1,360.00."

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Nassau

I, Tracy Morgan, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

04/08/2021
(Dated)

Tracy Morgan

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
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Electronically Signed

Your name: Tracy Morgan
Signed on: 04/08/2021